Child's Medical History and Registration Form

Name________________________________D.O.B.__________________Sex: M__F__
Address:____
Phone#____________________
Mother's work phone #________________________________
Father's work phone #_________________________________

Primary Dental Insurance Information: Name of Policy Holder:____________________________
Employer:________________________Address___________________
Name of Insurance Co.____________________________________Group #________________
Subscriber# or SSN_____________________

Person Financially Responsible: Name_______________________Phone#____________________
Address:____
Relationship to Child______________________________

Dental History

Date of last visit to dentist ___________________ For what service ______________________
Name of former dentist ___________________________________Phone#____________________
Name of Orthodontist____Phone #___________________
Has child complained about dental problems ☐ yes ☐ no ____________________________
Any unhappy dental experiences ☐ yes ☐ no____
Any injuries to mouth, teeth, head ☐ yes☐ no ____
Any mouth habits- thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier etc. ☐ yes ☐ no ____
Any unusual speech habits ☐ yes ☐ no ____
Any lost teeth ☐ yes ☐ no Have missing teeth been replaced ☐ yes ☐ no
Orthodontic appliances worn now or ever ☐ yes ☐ no
Does your child brush daily ☐ yes ☐ no How often __________________________
Is dental floss used ☐ yes ☐ no How often________________________________
Does an adult assist child with brushing ☐ yes ☐ no
Is fluoride taken in any form ☐ yes ☐ no How often__________________________
Child's attitude towards dentistry ____
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OVER →

Health History

Child's Physician ______________________________ Phone # ______________________

Date of last physician's exam ____________ Is child under care of physician now ☐ yes ☐ no

Does the child have good physical coordination ☐ yes ☐ no ____________________________

Are there any emotional problems ☐ yes ☐ no______________________________________

Is there any excessive bleeding when cut ☐ yes ☐ no

Is child on any medications ☐ yes ☐ no If so what __________________________________

Has the child ever been hospitalized ☐ yes ☐ no If yes for what ________________________

Is the child allergic to any antibiotics ☐ yes ☐ no If yes, list antibiotics __________________

Is the child allergic to other drugs ☐ yes ☐ no If yes, list drugs _________________________

Any allergies to food, pollen, animals, dust, metals, local anesthetics, latex. Please circle any that apply or list any allergies not listed ____

Has the child had any history or difficulty with any of the following:

___ Anemia
___ Asthma
___ Bladder
___Cancer
___ Chicken Pox
___ Thyroid
___ Other
___Chronic Sinus
___ Convulsions
___ Diabetes
___ Epilepsy
___ Fainting
___ Tuberculosis
___ Hearing
___ Heart
___ Kidney
___ Liver
___ Hepatitis
___ Sexually transmitted diseases
___Measles
___ Mononucleosis
___ Mumps
___ Rheumatic Fever
___HIV/AIDS

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information we should be aware of:

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This information was given by ______________________________Date ____________________
Relationship to child ____________________________